

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

Reg. Dist. No. 262

## 1. PLACE OF DEATH

County SomersetCity or town Rural Princess Anne Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 yearsHospital, institution, or street address where death occurred: IHow long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Rural Princess Anne Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. -  
(If rural, give LOCATION)2.(a) If veteran, name war -

## 3. (a) FULL NAME

John A. Brittingham

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Missouri A. Brittingham7. Birth date of deceased (mo., day, yr.) June 10, 18626. (c) If alive, give age - years8. AGE: Years 83 Months 10 Days 10 If less than one day - hrs. - min.9. Birthplace Rural Princess Anne Somerset Md.  
(Town, county, and state)10. Usual occupation Farming

## 11. Industry or business

12. Name Joe. Brittingham13. Birthplace Md.14. Maiden name Sallie Cottonson15. Birthplace Md.16. Informant Ernest BrittinghamAddress Princess Anne Md.17. Burial Date thereof Dec 23, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Emmanuel CemeteryLocation Rural Princess Anne Md18. Funeral director Margaretta H. WatsonAddress Rockville Md.19. Dec 23, 45 R. H. Johnson M.D. per g.d. Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20, 1945 at 11:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him - alive on - 19Immediate cause of death Arterio SclerosisDue to MyocardialDue to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE R. H. Johnson M. D. or otherAddress Princess Anne Md Date signed 12/22/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
DEC 29 1944  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12681-265

## 1. PLACE OF DEATH:

County SomersetCity or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

N. 4th Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. N. Fourth St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

James Wardell Cattingham

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

August 26, 1945

8. AGE:

Years

Months

Day

If less than one day

325

hrs.

min.

9. Birthplace

Marion Somerset, Md.  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Percy Lee Cattingham

13. Birthplace

Marion, Md.

14. Maiden name

Dorothea Craswell

15. Birthplace

Marion, Md.

16. Informant

Address

Percy Lee CattinghamCrisfield, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 26, 1945  
(month) (day) (year)

Cemetery or crematory

Wesley Family Burial Lot

Location

Marion, Md.

18. Funeral director

Address

George W. TilghmanCrisfield, Md.

19.

(Date rec'd by registrar)

19

B. E. Callins, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1945 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

No physician in attendance known

Due to

illness

Due to

from birth

Other condition

(Include pregnancy within 3 months of death)

## DURATION

3 mo.

2-3 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. E. Callins, M.D.

M. D. or other

Address

Crisfield, Md.

Date signed

12/20/45

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DEC 27 1945  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

12682

★ Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 18 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Maryland Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Grace Mae Dize

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) January 12, 1927 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 18 Months 11 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Crisfield-Somerset-Maryland  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name George Harlan Dize13. Birthplace Crisfield, Maryland14. Maiden name Minnie Dorman15. Birthplace Crisfield, Maryland16. Informant Mrs. Minnie DizeAddress Maryland Ave., Crisfield, Md.

17. Burial Date thereof Dec. 23, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Crisfield CemeteryLocation Crisfield, Maryland18. Funeral director H. Harvey BradshawAddress Crisfield, Maryland

19. 12/21/45 C. E. Collins, Md.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1945 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1945 to December 21, 1945  
 and that I last saw him alive on December 21, 1945

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Pneumonia \_\_\_\_\_  
Asthma \_\_\_\_\_  
Pharyngitis \_\_\_\_\_  
Chronic bronchitis \_\_\_\_\_  
Mental deterioration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Chas. R. Shuster M. D. or other \_\_\_\_\_  
 Address Crisfield, Md. Date signed 12/21/45

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JUN 10 1946  
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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

## CERTIFICATE OF DEATH

12683

Reg. Dist. No. 260

1. PLACE OF DEATH:  
County Prince Georges Md R.F.D.  
City or town Somerset  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? all life  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Somerset  
City or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

3. (a) FULL NAME  
Nathaniel E. Dryden

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife L

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1943 6.(c) If alive, give age ..... years

8. AGE: Years Months Days If less than one day  
8 1 13 hrs. min.

9. Birthplace Princess Anne, Somerset, Md  
(Town, county, and state)

10. Usual occupation None

11. Industry or business N

12. Name Fred J. Dryden

13. Birthplace Maryland

14. Maiden name Lucille Houser

15. Birthplace Maryland

16. Informant F. J. Dryden

Address Princess Anne, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 2, 1946  
(month) (day) (year)

Cemetery or crematory Chances

Location Chances, Md.

18. Funeral director J. Edgar Thomas

Address Accoage, Virginia

18. Jan 2 19 46 R. H. Johnson, M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 45 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him live on 19

Immediate cause of death Smothered while sleeping

DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/31/45

Where did injury occur? Princess Anne, Somerset, Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Smothered Injured at work? No

23. SIGNATURE Heuph. Seafford, M.D.

Address Princess Anne, Md

Date signed 12/31/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 11 1946  
BUREAU V E



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 12684

## 1. PLACE OF DEATH:

County Somerset  
 City or town Tylerton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 58 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town Tylerton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Edward F. Evans

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mary Kathryn Evans  
 7. Birth date of deceased (mo., day, yr.) Feb. 21 - 1887 6.(c) If alive, give age 1887 years  
 8. AGE: Years 58 Months 9 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Tylerton Somerset Md  
 (Town, county, and state)  
 10. Usual occupation Waterman  
 11. Industry or business Postmaster's Crabb  
 12. Name Willie Evans  
 13. Birthplace Sunnybrook Va.  
 14. Maiden name Willie Evans  
 15. Birthplace Tylerton Md

16. Informant Mrs. Edward F. Evans  
 Address Tylerton Maryland  
 17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec. 12 1945  
 (month) (day) (year)  
 Cemetery or crematory Tylerton Cemetery  
 Location Tylerton Maryland  
 18. Funeral director H. Harry Bradshaw  
 Address Crisfield Md  
 19. Dec 16 45 (Date rec'd by registrar) Carrie Kitching Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1945, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1945 to Dec. 9 1945  
 and that I last saw him alive on Dec. 9 1945  
 Immediate cause of death Chronic Valvular Heart Disease DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. S. Cabell M. D. or other \_\_\_\_\_Address Bwell Md Date signed 12-9-45

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DEC 20 1945

BUREAU V

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 266

### 1. PLACE OF DEATH:

County Somerset

City or town East Ewell  
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Ewell Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)

Street No. \_\_\_\_\_  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Mary Jane Evans

### 3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Caleb Westley Evans

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Mo. 10 1866

8. AGE: Years 79 Months 9 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Smith Island, Somerset, Md  
(Town, county, and state)

10. Usual occupation House wif

11. Industry or business

12. Name John H Marshall

13. Birthplace Smith Island Md

14. Maiden name Julia Ann Taylor

15. Birthplace Smith Island Md

16. Informant Mrs Mabel Evans

Address Ewell Md

17. Burial Date thereof Dec 23 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ewell Cemetery

Location Smith Island Md

18. Funeral director John A Bradshaw

Address Cristfield Md

19. 12/23/ 1945 Carrie Kitching  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 45 to Dec. 19 45 and that I last saw her alive on Dec. 18 19 45

Immediate cause of death Chronic Valvular Heart Disease

DURATION

Due to Arteriosclerosis

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W. J. Seabold

M. D. or other

Address Ewell Md Date signed 12-19-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12686

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset

City or town Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No. Charlotte Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war none

## 3. (a) FULL NAME

Nancy S. Harrison

## 3. (b) Social Security Number

none

4. Sex female

5. Color or race white

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Daniel W.

6.(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) April 24, 1863

8. AGE: Years 82 Months 7 Days 30

It less than one day hrs. min.

9. Birthplace Crisfield, Md.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

12. Name William T. Ward

13. Birthplace Md.

14. Maiden name Eliza Cullen

15. Birthplace Md.

16. Informant Mrs. James Bell

Address Crisfield, Md.

17. Burial Date thereof 12/26/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Crisfield Cemetery

Location Crisfield, Md.

Howard H. Hubbard

18. Funeral director

Address 306 Main St., Crisfield, Md.

19. 12/26/45 6. E. Cullen, M.D.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1945 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 - 1945, to Dec 23 1945,

and that I last saw him alive on Dec 23 - 45

Immediate cause of death

DURATION

Hemiplegia 8 days

Due to Atherosclerosis

Due to Hypertension 2 yrs,

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE B. E. Cullen

M. D. or other

Address Crisfield, Md.

Date signed 12/26/45

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JAN 2 1946  
BUREAU V. B.

ASTORIAN LETTER

HAD CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

## CERTIFICATE OF DEATH

Reg. Dist. No. 18687360

## 1. PLACE OF DEATH:

County Somerset CountyCity or town near Vernon  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Fred Horsey

## 3. (b) Social Security Number

4. Sex male5. Color or race colored6. (a) Single, married, widowed, or divorced single6. (b) Name of husband or wife april7. Birth date of deceased (mo., day, yr.) 14 18806. (c) If alive, give age 60 years8. AGE: Years 40 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Unknown  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Fred Horsey13. Birthplace Somerset County

14. Maiden name \_\_\_\_\_

15. Birthplace Somerset County16. Informant Mrs. John ParksAddress Princess Anne, Md.17. Burial Date thereof 12-30-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Alma HouseLocation near Princess Anne18. Funeral director Jimmie DennisAddress Princess Anne19. Dec. 30 45 R. H. Johnson, M.D.  
(Date rec'd by registrar) (Signature) RegistrarAddress Princess Anne MdDate signed Dec 30, 45

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him alive on Dec 14 1945Immediate cause of death ApoplexyDue to chronic nephritis -no cardiacDue to was an immediate causeOther conditions Alma House

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. H. Johnson M.D.Address Princess Anne MdDate signed Dec 30, 45

M. D. or other \_\_\_\_\_



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12688  
Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Samuel Jones

## 3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Mandy Jones7. Birth date of deceased (mo., day, yr.) Sept 10 - 1876 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 69 Months 2 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Princess Anne Somerset Co MD  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name William Jones13. Birthplace Somerset Co MD14. Maiden name or known

15. Birthplace

16. Informant Pearl CollinsAddress Westover Ind.17. burial Date thereof Dec 5 - 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GreenwoodLocation Princess Anne MD18. Funeral director Edgar H. WardAddress Marion MDDate rec'd by registrar Dec. 5, 1945 Registrar R. H. Johnson, M.D.Per g.d.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1<sup>st</sup> 1945, at 8:40 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1941, to Dec 1<sup>st</sup> 1945and that I last saw him alive on Dec 1 1945

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chronic bronchitis 4 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Edgar H. Ward M. D. or other \_\_\_\_\_Address Princess Anne MD Date signed 12-5-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
DEC 6 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12689

Reg. Dist. No. 260

## 1. PLACE OF DEATH

County SpencerCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

R.D. #1

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County SpencerCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #1  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Harry Kelley

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## B. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

No Recd 1920

## 6. (c) If alive, give age..... years

## 8. AGE:

25

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Snow Hill Maryland  
(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

## FATHER

## 12. Name

William Kelley

## 13. Birthplace

Surrey Co. Del.

## MOTHER

## 14. Maiden name

Ellie Griffin

## 15. Birthplace

Pomeroy Maryland

## 16. Informant

## Address

Mrs. Ellie Kelley  
Hasting St. Salisbury Md.

## 17. (Burial, cremation, or removal. Which?)

## Date thereof

BurialDec. 11-1945  
(month) (day) (year)

## Cemetery or crematory

Wango Am.

## Location

Wango Maryland

## 18. Funeral director

## Address

Holladay & Co. Walter R. Holladay  
Salisbury Maryland

## 19. (Date rec'd by registrar)

Dec. 1045R. A. Johnson, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1945 at 3.2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Gunshot wound of  
left chest

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

M. LANKFORD Date of op. Dec. 11-1945

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of 12/8/45Where did injury occur? R.F.D. (Princess Anne) (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Shot in chest Injured at work? No

23. SIGNATURE

Wm. M. Lankford M.D. M. D. & otherAddress Princess Anne Md. Date signed 12/10/45

RECEIVED BY THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

KFC  
DEC 11 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

12690

Reg. Dist. No. 265

FILM No. 100 JAN 11 1946

### 1. PLACE OF DEATH

County..... Somerset

City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Somerset

City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Johnsons Creek Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war..... none

### 3. (a) FULL NAME

John Henry Lawson

### 3. (b) Social Security Number

218-14-2521

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married

6.(b) Name of husband or wife..... Sadie A.

6.(c) If alive, give age..... 47 years

7. Birth date of deceased (mo., day, yr.)..... Oct. 11, 1869

8. AGE: Years..... 74 76 Months..... 2 Days..... 8 If less than one day..... hrs. .... min.

9. Birthplace..... Crisfield, Md.  
(Town, county, and state)

10. Usual occupation..... Salesman

11. Industry or business..... Self

12. Name..... William H. Lawson

13. Birthplace..... Md.

14. Maiden name..... Caroline

15. Birthplace..... Md.

16. Informant..... Sadie A. Lawson  
Address..... Crisfield, Md.

17. Burial..... Date thereof..... 12/20/45  
(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Asbury Cemetery  
Location..... Crisfield, Md.

18. Funeral director..... Howard H. Hubbard

Address..... 306 Main St., Crisfield, Md.

19. (Date rec'd by registrar)..... 12/20/45 Registrar..... C. E. Ballinger

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 18, 1945 19..... at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7 1945 to Dec 18 1945

and that I last saw him alive on Dec 17 1945

Immediate cause of death.....  
Central Nervous System  
Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... S. M. Peyton M.D.

Address..... Crisfield, Md. Date signed..... Dec 20, 1945

RECEIVED  
JAN 2 1946  
BUREAU V.R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ba*

## CERTIFICATE OF DEATH

12691

Reg. Dist. No. *270*

1. PLACE OF DEATH: *Somerset*  
 County.....  
 City or town..... *RFD Marion Station*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... *Life*  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... *Maryland* County..... *Somerset*  
 City or town..... *RFD Marion Station*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... *RFD*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... *none*

3. (a) FULL NAME  
*Georgianna Long*

3. (b) Social Security Number  
*none*

4. Sex *female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *widow*  
 6. (b) Name of husband or wife..... *Alexander Long*  
 B. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) *May 15, 1852*  
 8. AGE: Years Months Days If less than one day  
*93 6 25* .....hrs. ....min.

9. Birthplace..... *Somerset Co., Md.*  
 (Town, county, and state)  
 10. Usual occupation..... *housewife*  
 11. Industry or business..... *home*  
 12. Name..... *George Price*  
 13. Birthplace..... *Delaware*  
 14. Maiden name..... *Sarah R. Fletcher*  
 15. Birthplace..... *Md*

16. Informant..... *Lilly Sterling*  
 Address..... *Mariners Rd., Crisfield, Md*  
 17. (Burial, cremation, or removal. Which?) *Burial* Date thereof..... *12/13/45*  
 (month) (day) (year)  
 Cemetery or crematory..... *St Pauls*  
 Location..... *RFD Marion Station, Md.*  
 18. Funeral director..... *Howard H. Hubbard*  
 Address..... *506 Main St., Crisfield, Md.*  
 19. *12/13/45* *E. E. Collins, M.D.*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Dec. 10, 1945* 19....., at..... *9:55P M*  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*Mr. 1* 19..... *45* to..... *Dec 10* 19..... *45*  
 and that I last saw h..... alive on..... *Dec 10* 19..... *45*

Immediate cause of death.....  
*Heart Dec 7, 1945*  
 DURATION  
*2 weeks*  
 Due to..... *Coronary Artery Sclerosis*  
*Arteriosclerosis* 10 yrs.  
 Due to..... *General Arteriosclerosis*  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... *Suzanne D. Dordman* M. D. or other  
 Address..... *Mumori et al mo* Date signed..... *Dec 12, 45*

RECEIVED

DEC 27 1945

BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

12692

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County..... Somerset  
 City or town..... Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 40 yrs.  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Somerset  
 City or town..... RFD Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Jacksonville Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... none

## 3. (a) FULL NAME

Benjamin S. Mills Sr.

## 3. (b) Social Security Number

none

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Addie E. 6.(c) If alive, give age..... 75 years  
 7. Birth date of deceased (mo., day, yr.)..... February 19, 1863  
 8. AGE: Years..... 82 Months..... 9 Days..... 20 It less than one day..... hrs. .... min.

9. Birthplace..... Upper Marlboro Md.  
 (Town, county, and state)  
 10. Usual occupation..... Retired Yard Master  
 11. Industry or business..... Penn RR  
 12. Name..... James Mills  
 13. Birthplace..... Md.  
 14. Maiden name..... Fannie  
 15. Birthplace..... Md.

16. Informant..... Addie E. Mills  
 Address..... RFD Crisfield, Md.  
Burial  
 17. (Burial, cremation, or removal. Which?) Date thereof..... 12/11/45  
 (month) (day) (year)  
 Cemetery or crematory..... Sunny Ridge  
 Location..... Crisfield, Md.  
 18. Funeral director..... Howard H. Hubbard  
 Address..... 306 Main St., Crisfield, Md.  
12/10/45 G. E. Galligan Sr.  
 19. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 9, 1945 at 4.35P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 9 1945  
 and that I last saw him alive on Dec 9 1945  
 Immediate cause of death..... Ac bil. Heart

Interm Sclerosis  
 DURATION 5 days  
 Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... G E Galligan M. D. or other  
 Address..... Crisfield Md. Date signed..... 12-10-45

RECEIVED  
DEC 27 1945  
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

12693

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William T. Pusey

## 3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary C. PuseyB.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.)

April 23, 1862

8. AGE:

Years

Months

Days

If less than one day

8381

hrs.

min.

9. Birthplace

Princess Anne, Md.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Frank Pusey

13. Birthplace

Princess Anne, Md.

14. Maiden name

Unknown

15. Birthplace

18. Informant

William Pusey

Address

Princess Anne, Md.

17. (Burial, cremation, or removal, Which?)

Date thereof Dec. 21, 1945  
(month) (day) (year)

Cemetery or crematory

Palmetto Cemetery

Location

Princess Anne, Md.

18. Funeral director

Paul Dashiell

Address

Princess Anne, Md.

19. (Date rec'd by reg.)

Dec. 26, 1945  
R. N. Johnson, M.D.  
Per g.d.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 24, 1945

at

1945

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18

to

19

and that I last saw him

alive on

19

Immediate cause of death

Arterio Sclerosis

DURATION

Arterio Sclerosis

Due to

Due to

Other conditions

Comp. Fracture of leg  
about one year ago. Not healed  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Smith

M. D. or other

Address

Princess Anne, Md.Date signed 12/20/45

RECEIVED  
JAN 4 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

## CERTIFICATE OF DEATH

12694

Reg. Dist. No. 268

## 1. PLACE OF DEATH:

County SomersetCity or town Chance, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Chance, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Frank C. Stoiber

## 3. (b) Social Security Number

None4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorcedMarried6.(b) Name of husband or wife Eloris Stoiber6.(c) If alive, give age 29 years7. Birth date of deceased (mo., day, yr.) Feb. 28, 19158. AGE: Years 30 Months 9 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Sheffield Pa.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John Stoiber13. Birthplace Sheffield Pa.14. Maiden name Theresa Stoiber15. Birthplace Sheffield Pa.16. Informant Walter StoiberAddress Chance, Md.17. Burial Date thereof Dec 24, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chance CemeteryLocation Chance, Maryland18. Funeral director Walter H. HaskellAddress Princess Anne Md.19. Dec 20 1945 Rosa Neuber  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17th 1945 at 9a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_, and that I last saw him \_\_\_\_\_ 19\_\_\_\_\_

Immediate cause of death Pulmonary embolism

Other conditions \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

## DURATION

ImpHours

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Shirley (Not in attendance)

M. D. or other \_\_\_\_\_

Address Chance, Md Date signed 12/17/45



DEC 29 1945  
BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1762

## CERTIFICATE OF DEATH

Reg. Dist. No. 12695 260

## 1. PLACE OF DEATH:

County Somerset  
 City or town Princess Anne, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life time  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war .....

## 3. (a) FULL NAME

Leola Thomas

## 3. (b) Social Security Number

4. Sex F 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) February 29, 1912  
 6. (c) If alive, give age ..... years

8. AGE: Years 33 Months 10 Days ..... It less than one day  
 ..... hrs. .... min.

9. Birthplace Princess Anne, Md.  
 (Town, county, and state)

10. Usual occupation House Wife.

## 11. Industry or business

12. Name Samuel Pollitt13. Birthplace Princess Anne, Md.14. Maiden name Hennetta Belphemon15. Birthplace Princess Anne, Md.16. Informant James PollittAddress Princess Anne Md

17. Burial Date thereof 1-1-1946  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory John WesleyLocation Princess Anne, Md.18. Funeral director William James & SonAddress Princess Anne, Md.

19. Jan. 1 19 46 R. H. Johnson, Md.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 19 45 at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Internal hemorrhage following a fall

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/28/45

Where did injury occur? Princess Anne, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury 12/28/45 Injured at work? No

23. SIGNATURE Henry M. Loufford, Md. M. D. or other

Address Princess Anne, Md. Date signed 12/30/45

RECEIVED

JAN 3 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 367

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Somerset  
 City or town RFD Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War 1

## 3. (a) FULL NAME

Isaac J. Tyler

## 3. (b) Social Security Number

none

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
6. (b) Name of husband or wife <u>Blanche D.</u>		
B. (c) If alive, give age <u>38</u> years		
7. Birth date of deceased (mo., day, yr.) <u>April 8, 1888</u>		
8. AGE: Years <u>57</u>	Months <u>8</u>	Days <u>12</u> If less than one day .....hrs. ....min.

9. Birthplace Crisfield, Md.  
 (Town, county, and state)  
 10. Usual occupation Waterman  
 11. Industry or business self

12. Name William H. Tyler  
 13. Birthplace Md.  
 14. Maiden name Sarah C. Tyler  
 15. Birthplace Md.

16. Informant Blanche D. Tyler  
 Address RFD Crisfield, Md.  
 17. Burial Date thereof 12/23/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory American Legion Cemetery  
 Location Crisfield, Md.

18. Funeral director Howard H. Hubbard  
 Address 306 Main St., Crisfield, Md.

19. 12/23/45 B. E. Collier, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1945 19..... at 4 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 24, 1945 to Dec 20, 1945  
 and that I last saw him alive on Dec. 20, 1945

Immediate cause of death Cardio-vascular disease, myocarditis, coronary disease  
 Due to Syphilis

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Chas. Schwab  
 M. D. or other \_\_\_\_\_  
 Address Crisfield Date signed 12/23/45

RECEIVED  
JAN 2 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset

City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. 308 Locust Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Amanda K. Walters

7. Birth date of deceased (mo., day, yr.) November 4, 1866

8. AGE: Years 79 Months 11 Days 4  
If less than one day hrs. min.9. Birthplace Deal's Island-Somerset-Md.  
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Sea food

12. Name George Walters

13. Birthplace Deal's Island Md

14. Maiden name Sarah Webster

15. Birthplace Deal's Island Md.

16. Informant Mrs. Marion Somers

Address Crisfield, Md.

17. Burial Date thereof Dec. 18, 1945

(Burial, cremation, or removal. Which?)

Cemetery or crematory Crisfield Cemetery

Location Crisfield, Md.

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Md.

19. 12/18/45 1945

(Date rec'd by registrar) Registrar G. B. Collins, Md.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1940 to Dec 16 1945

and that I last saw him alive on Dec 16 1945

Immediate cause of death

Crown artery disease

## DURATION

5-6 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. J. Somers

Address Crisfield Md

Date signed 12-18-45

RECEIVED  
DEC 27 1945  
BUREAU V M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

## CERTIFICATE OF DEATH

Reg. Dist. No. 1269870

## 1. PLACE OF DEATH: Somerset

County.....Crisfield

City or town.....Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

McCreedy Memorial Hosp.

4 days

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....Somerset

City or town.....Crisfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. Standard Ave.  
(If rural, give LOCATION)

none

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Margaret Ellen Ward

## 3. (b) Social Security Number

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced single
------------------	---------------------------	--

6. (b) Name of husband or wife.....none

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1945

8. AGE:	Years	Months	Days	If less than one day
			23	hrs. min.

9. Birthplace.....Crisfield  
(Town, county, and state)

10. Usual occupation.....none

11. Industry or business.....none

12. Name.....Howard Ward

13. Birthplace.....Md.

14. Maiden name.....Fannie Landon

15. Birthplace.....Md.

18. Informant.....Howard Ward

Address Standard Ave., Crisfield, Md.

17. Burial Date thereof.....12/22/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Sunny Ridge Cemetery  
Location.....Crisfield, Md.

18. Funeral director.....Howard H. Hubbard

Address 306 Main St., Crisfield, Md.

19. 12/21/45 19.....B. E. Hubbard, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1945 19..... at 1.20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 14 1945 to Dec 21 1945

and that I last saw her alive on Dec 20 1945

Immediate cause of death.....

Pneumonia

DURATION 5 days

Due to.....

Due to.....

Due to.....

Other conditions.....

Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....S. M. Peyton M.D.

Address.....Crisfield, Md.

Date signed.....Dec 21, 1945

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JAN 2 1946  
BUREAU V.A.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 882

## CERTIFICATE OF DEATH

Reg. Dist. No. 12699 260

### 1. PLACE OF DEATH:

County Somerset  
City or town Upper Hill  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 87 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Somerset  
City or town Upper Hill  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
8.(b) Name of husband or wife Stanton Williams  
7. Birth date of deceased (mo., day, yr.) Jan 8-1882  
8. AGE: Years 83 Months 11 Days 22 It less than one day  
hrs. min.

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 24 1945 at 1:24 PM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
and that I last saw him alive on

Immediate cause of death Central Nervous System  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur?  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

11. Industry or business  
12. Name George Wilson  
13. Birthplace Hualock md  
14. Maiden name Hester Jones  
15. Birthplace Upper Hill md  
16. Informant Mrs Graham Warner  
Address Upper Hill md  
17. Buried Date thereof Dec 28-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Upper Hill  
Location Upper Hill md  
18. Funeral director Chas H Ward  
Address Mansion Road  
19. Dec 28 45 R H Johnson M.D.  
(Date rec'd by registrar) (Signature) Registrar

23. SIGNATURE Wm M. Loupford M.D.  
M. D. or other  
Address Frederick md  
Date signed 12/26/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 29 1945  
BUREAU V. A.

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16

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-0)

## CERTIFICATE OF DEATH

Reg. Dist. No. 261

### 1. PLACE OF DEATH:

County Somerset

City or town Marion  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Council

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Somerset

City or town Marion  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Council L. Whittington

### 3. (b) Social Security Number

214-08-5850

4. Sex M 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Estella Whittington

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1886

8. AGE: Years 59 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marion, Somerset Co., Md.  
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name Philip Whittington

13. Birthplace Marion Station, Md.

14. Maiden name Hanna Weenies

15. Birthplace Marion Sta., Md.

16. Informant Estella Whittington

Address Marion Sta., Md.

17. Burial Date thereof Dec. 11, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Branch

Location Marion Sta., Md.

18. Funeral director Charles H. Hard

Address Marion Sta., Md.

19. Dec 11 1945 Chas H Hard  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1945 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Dec 7 1945

and that I last saw him alive on Dec 5 1945

Immediate cause of death

Acute Dilated Heart

Myocard

Due to \_\_\_\_\_

Due to Chronic Dilated Heart

Chronic myocarditis

Other conditions generalized atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Chas H Hard M. D. or other \_\_\_\_\_

Address Marion Sta., Md. Date signed Dec 8 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
DEC 12 1945  
BUREAU V.B.

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore 922

# CERTIFICATE OF DEATH

Reg. Diat. No. ....

<p><b>1. PLACE OF DEATH:</b></p> <p>County... <u>Somerset</u></p> <p>City or town... <u>Cornfield</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small></p> <p>How long in above place of death? <u>5 yrs</u></p> <p>Hospital, institution, or street address where death occurred:</p> <p>How long in hospital or institution?</p>		<p><b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> <small>(For newborn infants give residence of mother)</small></p> <p>State... <u>Md</u> County... <u>Somerset</u></p> <p>City or town... <u>Cornfield</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small></p> <p>Street No..... <small>(If rural, give LOCATION)</small></p> <p>2(a) If veteran, name war.....</p>									
<p><b>3. (a) FULL NAME</b> <u>Samuel Hezekiah Williams</u></p>		<p><b>3. (b) Social Security Number</b></p>									
<p><b>4. Sex</b> <u>Male</u></p>	<p><b>5. Color or race</b> <u>Negro</u></p>	<p><b>6. (a) Single, married, widowed, or divorced</b> <u>Widow</u></p>									
<p><b>6. (b) Name of husband or wife</b> <u>Addie Williams</u></p>		<p><b>6. (c) If alive, give age</b> ..... years</p>									
<p><b>7. Birth date of deceased (mo., day, yr.)</b> <u>Aug 29, 1886</u></p>											
<p><b>8. AGE:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Years</th> <th>Months</th> <th>Days</th> <th>If less than one day</th> </tr> </thead> <tbody> <tr> <td align="center"><u>59</u></td> <td align="center"><u>3</u></td> <td align="center"><u>27</u></td> <td>hrs. min.</td> </tr> </tbody> </table>				Years	Months	Days	If less than one day	<u>59</u>	<u>3</u>	<u>27</u>	hrs. min.
Years	Months	Days	If less than one day								
<u>59</u>	<u>3</u>	<u>27</u>	hrs. min.								
<p><b>9. Birthplace</b> <u>Cornfield, Ind.</u> <small>(Town, county, and state)</small></p>											
<p><b>10. Usual occupation</b> <u>Oyster opener</u></p>											
<p><b>11. Industry or business</b> <u>Oyster Packing</u></p>											
<p><b>12. Name</b> <u>Samuel Williams</u></p>											
<p><b>13. Birthplace</b> <u>Marion, Ind.</u></p>											
<p><b>14. Maiden name</b> <u>Sally Anne Jewett</u></p>											
<p><b>15. Birthplace</b> <u>Cornfield, Ind.</u></p>											
<p><b>16. Informant</b> <u>Sally Anne Jewett</u> <b>Address</b> <u>Cornfield, Ind.</u></p>											
<p><b>17. Burial</b> <u>Buried</u> Date thereof <u>Dec 26, 1945</u> <small>(Burial, cremation, or removal. Which?) (month) (day) (year)</small></p>											
<p><b>Cemetery or crematory</b> <u>Lawnview</u></p>											
<p><b>Location</b> <u>Cornfield, Md</u></p>											
<p><b>18. Funeral director</b> <u>Chas H Ward</u></p>											
<p><b>Address</b> <u>Marion, Ind.</u></p>											
<p><b>19.</b> <u>12/24/45</u> <b>19</b> <u>E E Collier M.D.S.</u> <small>(Date rec'd by registrar) Registrar</small></p>											

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 21, 1945, at 1 A

**21. I CERTIFY** that death occurred on the date above stated: that I attended deceased from Dec. 21, 1945, to Dec. 21, 1945, and that I last saw him alive on Dec. 21, 1945.

**Immediate cause of death** Heart insufficiency

**Due to** Coronary Arteriosclerosis

**Other conditions**

**DURATION**  
Sept. 1943  
Dec 21, 1945

**Major findings of operations**

Date of op. ....

**Autopsy results**

**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

**23. SIGNATURE** W. J. Brinkley M.D. M. D. or other

**Address** Cornfield, Ind. Date signed 12/24/45



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JAN 2 1946  
BUREAU V.R.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12702 760

## 1. PLACE OF DEATH:

County SomersetCity or town Mt Vernon, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Mt Vernon, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas A. Windsor

## 3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

widowed6.(b) Name of husband or wife Annie Windsor

7. Birth date of

deceased (mo., day, yr.)

March 15, 1873

8.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

72828

hrs.

min.

9. Birthplace Wales Island, Md.  
(Town, county, and state)10. Usual occupation Waterman + Painter

11. Industry or business

12. Name Edridge Windsor13. Birthplace Wales Island, Md.14. Maiden name Mary Webster15. Birthplace Wales Island, Md.16. Informant Mrs Albert Mason

Address

Mt Vernon, Md.17. Burial Date thereof Dec. 15, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Asbury Cemetery

Location

Mt Vernon, Md.18. Funeral director Wales Warfield

Address

Princess Anne, Md.19. Dec. 15, 1945 R. N. Johnson, M.D.  
(Date rec'd by registrar) (month) (day) (year) Registrar23. SIGNATURE Alvinich M. D. or otherAddress Princess Anne, Md. Date signed 12/18/45

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1945 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19\_\_\_\_, to 19\_\_\_\_

and that I last saw him alive on 19\_\_\_\_

Immediate cause of death Arteriosclerosis Myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

RECEIVED  
DEC 29 1945  
BUREAU V &

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1780

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town New Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

no

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 404 Lake Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

no

## 3.(a) FULL NAME

George D. Wright

## 3.(b) Social Security Number

no

4. Sex

Male

5. Color or race

aa

6.(a) Single, married, widowed, or divorced

married

B.(b) Name of husband or wife

Marguerite D. Wright6.(c) If alive, give age 27 years

T. Birth date of

deceased (mo., day, yr.) 4-10-20

8. AGE:

Years

25

Months

8

Days

16

If less than one day

hrs.

min.

9. Birthplace

Salisbury, Wicomico Co., Maryland  
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER  
MOTHER

12. Name

Marion F. Wright

13. Birthplace

Fruitland, Maryland

14. Maiden name

Cora F. Farniss

15. Birthplace

Eden, Maryland

16. Informant

Mrs. Marguerite Wright

Address

404 Lake Street, Salisbury, Md.

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

12/31/45  
(month) (day) (year)

Cemetery or crematory

Mt. Calvary Cemetery

Location

Fruitland, Maryland

18. Funeral director

James F. Stewart

Address

402 E. Church St., Salisbury, Md.

19.

(Date rec'd by registrar)

19.

Dec 31 1945 R. H. Johnson, M.D.

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

12/2619. 41 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 19, 10. 19

Immediate cause of death

Broken neck & other  
serious injuries

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

12/26/45

Where did injury occur?

New Market, Somerset Co.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Highway

Means of injury

Auto accident

Injured at work?

No

23. SIGNATURE

Wm. H. Soufford, M.D.

M. D. or other

Address

2nd

Date signed

12/18/45

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JAN 3 1946  
BUREAU V.B.